PRINTED: 08/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G496	B. WINC	3 <u> </u>		07/11/	2014
NAME OF P	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP CODE		
					/ESTDALE CT		
BONA VI	STA PROGRAMS	INC	KOKOMO, IN 46902				
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG W000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DETERMET)		DATE
VV000000							
	This visit was fo	or the investigation of	Woo	00000	In response to the findings of	of	
	complaint #IN0	_	'' '		the Complaint	J.	
	complaint wir to	0121009.			Surveyconducted on July 11	1	
	Complaint #IN0	00151089			2014, and to ensure	•,	
	-	ΓED, Federal and State			compliance with all		
		ated to the allegations are			establishedstandards and		
	cited at W149 a	C			policies and procedures, the		
	onou at With a	iid ii 100.			agency will implement the	•	
	Dates of Survey	· 7/7 7/8 7/9 7/10 and			followingplan of corrections	c.	
	Dates of Survey: 7/7, 7/8, 7/9, 7/10, and 7/11/2014.				All Residential House	3.	
	//11/2014.				Managers will be instructed		
	Facility Number	r· 001010			toconduct a training on	L	
	Provider Number				incident reporting for all sta	ff	
	AIM Number:				working in the home on	.11	
	Alivi Nullibel.	100243040				• • 1	
	Commerce				, ,		
		OIDB					
	Susan Eakright,	QIDF			_	e	
	There follows I de	Sisionalisa alaa madaat					
					_	-	
	_	accordance with 460				.I	
		mploted 7/21/14 by Buth					
	Siluenenoru, Qibi	•			_		
						T.	
					· · · · · · · · · · · · · · · · · · ·		
						led	
					agency policies and procedu	ıres	
	Surveyor: Susan Eakright, These federal destate findings in IAC 9.	QIDP eficiencies also reflect accordance with 460 mpleted 7/21/14 by Ruth			aquarterly basis during form staff meetings. The Residen House Managerswill then be required to submit meeting agendas and record of training to the Director of Residentian Services to ensure that the required training was completed. In the event that an incident not reported to the appropriate supervisory staff in a timely manner, the staff that were involved in or had knowledge of the incident that occurred will be retrained and counsed on incident reporting and agency policies and procedure.	etial e ings l is ite	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001010

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		A. BUILDING B. WING	COMPLETED 07/11/2014						
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT						
BONA VI	STA PROGRAMS II	NC	KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	REGOLATION ON			in regardsto incident reportions to ensure that all clients residing in the groupsetting not receive further repercussions or ramification following BDDSreportable incidents that occur in the home the agency will assume that allresidences in the home have been affected by the incident that occurred. Therefore, in the event that any such incident should occur again, the Residential Services Department will contact the agency Behavioral Consultantto address the events. The Behavior Consultant will meet with each client to discuss said events. When all meetings have been completed, the Behavior Consultant will submit a report that will include who was present for meetings and what was discussed. Notations of thes meetings will be place in all clientfiles. If it is determinent that further attention is need the Behavior Consultant will conduct follow-up meetings	ng. do ns ne ne ne de de de ded,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
		15G496	B. WIN			07/11/	2014	
	PROVIDER OR SUPPLIER		_ (2333 W	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT MO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID BROWIDER'S BLANCE CORRECT			(X5)	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE	
					with affected clients and QualifiedDevelopmental Disabilities Professional (QDDP). Refer to Appendix behavior consultation form be used.			
W000149	written policies an mistreatment, neg Based on record for 1 of 7 BDDS Developmental I Reports reviewed neglected to immallegation of clie unsupervised and staff were on dut based on client A Findings include On 7/7/14 at 2:10 (Bureau of Deve Services) Report reviewed from 0 and indicated the -A 6/15/14 BDD on 6/14/14 at 5:4 reported to the Q Developmental I	evelop and implement d procedures that prohibit lect or abuse of the client. review and interview, (Bureau of Disabilities Services) d (client A), the facility nediately report an ent A being left d neglected to ensure by to supervise client A a's identified needs. Expenditure of Disabilities is and investigations were 4/1/14 through 07/07/14 et following: S report for an incident expenditure of the spenditure of the spe	Woo	00149	To ensure that established agency policies and procedures for incident reporting is being implement and executed as written, the following correction actions will be implemented: 1) All st located at the location of 2333 Westdale Court (Westdale grohome) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13:Incide Reporting. Completed Record Trainings will be obtained and submitted upon completion of training. Refer to Appendix B frecord of Training form to be used.	taff up e d ent of	08/10/2014	

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G496	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/11/2014			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
	the consumers of the Westdale Group Home reported to staff [name] (when that staff reported for duty) that [client A] had been left in the house unattended when all else (sic) left on an outing yesterday (6/14/14)." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) "spoke with a few consumers who verified this claim" and an investigation was initiated. The report indicated on 6/15/14 the two staff on duty were suspended at that time. On 7/7/14 at 2:16pm, the facility's 6/16/14 investigation indicated client A was "left home alone" on 6/14/14 and the facility's staff failed to immediately report the allegation. The investigation indicated "Substantiated the findings to support the event as described," client A was left at home alone for "about 5 minutes" because he was "asleep" in his bedroom. The investigation results indicated the clients were leaving to go out to eat in the community, the clients loaded on the van with two staff, and once at the restaurant it was discovered that client A was not on the van. The investigation included witness statements from the staff in which the staff indicated they did not immediately report the allegation, however the clients from the group home reported to a different staff.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G496	B. WINC	3 <u> </u>		07/11/	2014
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			2333 WESTDALE CT				
BONA VI	STA PROGRAMS I	INC		KOKOM	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ess statement from					
		(DS #1) indicated client					
		"alone." DS #1 stated					
	"[client A] was a	_					
	bedroomDid y	ou notify anybody that					
	this happened? (Response) No, didn't					
		lYou didn't think to call					
	the on call? (Re	sponse) with everything					
	going on, I didn'	t even think about it."					
	-A 6/15/14 witne	ess statement from DS #2					
	indicated client	A was left home alone					
	without supervis	sion. DS #2 stated					
	"[client A] didn'	t even know, he was still					
	sleeping. Did yo	ou report this to anyone?					
	(Response) No,	•					
	-A 6/15/14 witne	ess statement from the					
	OIDP indicated	"Sunday morning					
		Westdale group home					
		form me that some					
	` ′	reporting to him that on					
		on 6/14/14 staff had left					
	[client A] alone						
	Client A's record	d was reviewed on 7/8/14					
		ent A's 1/10/14 ISP					
		oort Plan) and 3/2012					
		Support Plan) indicated					
	`	be supervised by the					
		ient A's ISP and BSP					
	1 -						
		ed behaviors of Physical					
		bal Aggression, Property					
	Destruction/abus	se, Resists supervision,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI 07/11	
		15G496	B. WIN			07/11/	/2014
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BONA VI	STA PROGRAMS I	NC			/ESTDALE CT //O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and Extreme Irri	tability. Client A's ISP					
	and BSP indicate	ed client A lived in a					
	group home with	n twenty-four hour staff					
	supervision. Cli	ent A's BSP indicated					
	"Staff will mon	nitor [Client A] every 15					
	minutes during p	orivate time to ensure					
	[client A] is not	engaging in potentially					
	harmful activitie	s. Staff will document					
	the 15 minute ch	ecks during private time					
	for monitoring a	nd safety purposes."					
	Client A's ISP in	dicated goals/objectives					
	to dial his parent	s phone number, to wear					
	his hearing aid o	n a daily basis, to wear					
	his glasses, to ch	eck his blood sugar, to					
	review how muc	h money an item costs,					
	to display approp	oriate social interactions,					
	to refrain from g	ossiping, to comply with					
	staff requests, to	clean his room, to					
	prepare a side di	sh, to put away his					
	clothing, to shav	e his face, to use					
	mouthwash, and	to follow a diabetic diet.					
	On 7/7/14 at 3:30	0pm, an interview with					
		(Vice President of					
	Residential Serv	ices), and the agency					
	nurse was condu	cted. The three					
	administrative st	aff stated client A was					
	"not safe" home	alone. The VPRS and					
	the QIDP both ir	ndicated client A lacked					
	-	t in an emergency, phone					
		e group home, and					
	_	The VPRS and QIDP					
	_	as neglect" when client A					
		one and "it was neglect					
							l .

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED				
		15G496	B. WING		07/11/2014				
NAME OF E	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE					
				2333 WESTDALE CT					
BONA VI	STA PROGRAMS	INC	коко	MO, IN 46902					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA					
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE				
	` ′	staff tried to cover it up."							
		eated the two staff							
	continued and fi	nished their shift that							
	night on 6/14/14	and were suspended on							
	6/15/14 after the	e clients from the group							
	home reported the	he incident. The VPRS							
	stated "no staff"	had reported the							
		e the clients reported it to							
		on 6/15/14 who contacted							
		VPRS indicated the							
	-	elected to provide							
		client A and neglected to							
	•	ort the incident to the							
		er BDDS policy and							
	procedure.	i bbbs policy and							
	procedure.								
	On 7/7/14 at 3:3	0pm, a record review							
		of the 6/11/2002 BDDS							
	"Incident Repor								
	_	ated "Neglect, includes							
	•	e appropriate care, food,							
	medical care, or	supervision"							
	_	m, a record review was							
		e facility's undated policy							
	_	for Abuse, Neglect,							
	Exploitation ind	icated "Abuse, Neglect,							
	Exploitation" ne	glect was defined as							
	"failure to provi	de goods and/or services							
	necessary for the	e individual to avoid							
	physical harm.	Failure to provide the							
		ry to an individual's							
		nd social well being.							
	Failure to meet	_							
	i undie to meet	and dubic need							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G496	B. WING			07/11/	2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2333 WESTDALE CT KOKOMO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DEFICIENCY)	
W000153	clothing and to penvironment" failure to implem plans could also The policy indicashould immediate abuse, neglect, a administrator and with State Law. This federal tag a #IN00151089. 9-3-2(a)	ch as food, shelter, provide a safe The policy indicated ment clients' program be considered neglect. ated the facility staff rely report allegations of ind/or mistreatment to the d to BDDS in accordance relates to complaint					
W000153	of mistreatment, n injuries of unknow immediately to the officials in accorda through establishe Based on record for 1 of 7 BDDS Developmental I Reports reviewed failed to immediate	ensure that all allegations eglect or abuse, as well as a source, are reported administrator or to other ance with State law ed procedures. review and interview, (Bureau of Disabilities Services) d (client A), the facility ately report an allegation to A being left home accordance with State	W00	00153	To ensure that established agency policies and procedures for incident reporting is being implement and executed as written, the following correction actions will be implemented: 1) Alls to located at the location of 2333 Westdale Court (Westdale grohome) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13:Incide	taff up	08/10/2014

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	15G496		LDING		07/11/	
		100400	B. WIN			077117	2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	Reporting. Completed Record	of	DATE
	On 7/7/14 at 2:16pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 04/1/14 through 07/07/14 and indicated the following:				Trainings will be obtained and submitted upon completion of training. Refer to Appendix B to Record of Training form to be		
					used.		
	-A 6/15/14 BDD	S report for an incident					
	on 6/14/14 at 5:4	15pm, indicated "it was					
	reported to the Q	DDP (Qualified					
	Developmental I	Disabilities Professional)					
	around 8:00am t	his morning 6/15/14 that					
	the consumers of	f the Westdale Group					
	•	o staff [name] (when that					
	_	duty) that [client A] had					
	been left in the h	ouse unattended when					
		on an outing yesterday					
	(6/14/14)." The	report indicated the					
	QIDP (Qualified	Intellectual Disabilities					
	Professional) "sp	ooke with a few					
	consumers who	verified this claim" and					
	an investigation	was initiated. The report					
	indicated on 6/1:	5/14 the two staff on duty					
	were suspended	at that time.					
	On 7/7/14 at 2:1	6pm, the facility's					
		ation indicated client A					
		lone" on 6/14/14 and the					
	facility's staff fai	iled to immediately					
		tion. The investigation					
		antiated the findings to					
		t as described," client A					
		alone for "about 5					
	minutes" becaus	e he was "asleep" in his					
		*					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496			LDING	NSTRUCTION 00	(X3) DATE COMPL 07/11/	ETED	
	PROVIDER OR SUPPLIER		_ .	2333 W	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT IO, IN 46902	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated the clied out to eat in the cloaded on the value once at the restant that client A was investigation inception from the staff in they did not immallegation, howe group home report of the control of the cont	cou notify anybody that Response) No, didn'tYou didn't think to call sponse) with everything t even think about it." ess statement from DS #2 A was left home alone tion. DS #2 stated t even know, he was still ou report this to anyone?					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G496		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2014		
	ROVIDER OR SUPPLIER STA PROGRAMS I		233	3 WEST	ESS, CITY, STATE, ZIP CODE DALE CT IN 46902		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CF	ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Saturday afterno	on 6/14/14 staff had left					
	[client A] alone						
	[]						
	On 7/7/14 at 3:3	0pm, an interview with					
		S (Vice President of					
	Residential Services), and the agency						
	nurse was condu	,,					
		aff stated client A was					
		alone. The VPRS and					
	-	ndicated client A lacked					
		t in an emergency, phone					
	, .	e group home, and					
	-	The VPRS and QIDP					
		ne incident was not					
		orted to the facility's					
	administrator an	d should have been.					
		relates to complaint					
	#IN00151089.						
	9-3-2(a)						

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Facility ID: 001010

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